

11916

## 1194 CERTIFICATE OF DEATH

Reg. Dist. No. 351

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>WORCESTER</u>		MARYLAND		STATE <u>M.D.</u>		COUNTY <u>WORCESTER</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>NEWARK.</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>NEWARK</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) (Middle) (Last) <u>CHARLES SAMUEL ADKINS</u>				(Month) (Day) (Year) <u>NOV. 15 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JUNE 17, 1892</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLIC SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>NEWARK MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES ADKINS</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE HENDERSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Mrs. C. S. ADKINS NEWARK MD</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A) _____				<u>Cerebral Thrombosis</u>			
ANTECEDENT CAUSE(S) DUE TO _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO _____							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				INTERVAL BETWEEN ONSET AND DEATH _____			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/15, 1956</u> , to <u>11/15, 1956</u> , that I last saw the deceased alive on <u>11/15, 1956</u> , and that death occurred at <u>11/15</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Thomas L. Jones, M.D.</u>				ADDRESS (Street, city, town, state) <u>1116 Hill Rd</u>		DATE SIGNED <u>11/16/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11/17/56</u>		NAME OF CEMETERY OR CREMATORY <u>BOWEN</u>		LOCATION (City, town, or county) (State) <u>NEWARK MD</u>	
24. REC'D BY REGISTRAR <u>Blair Cooper</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burboys</u>		ADDRESS <u>Burboys</u>	
DATE <u>NOV 19 1956</u>							

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11917  
11941 CERTIFICATE OF DEATH Reg. Dist. No. 355

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>WORCESTER</b> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>BERLIN</b>	STATE <b>MD</b> COUNTY <b>WORCESTER</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>BERLIN</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (Type or Print) <b>KATHERINE VERNETTE BIRCH</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>Nov. 8 1956</b>	
5. SEX: <b>F</b>	6. COLOR OR RACE: <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>	8. DATE OF BIRTH: <b>SEPT. 26, 1862</b>
9. AGE last birthday <b>94</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country): <b>BERLIN MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>JAMES RAYNO</b>		14. MOTHER'S MAIDEN NAME: <b>MARTHA PHILLIPS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT & ADDRESS: <b>MRS. GLADYS DAVIDSON, BERLIN MD</b>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <b>Cerebral Hemorrhage</b>			<b>5 hours</b>
ANTECEDENT CAUSE (B) <b>Arterio sclerosis</b>			<b>8 years</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <b>Senility</b>			<b>10 years</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Nov 9, 1956</b> to <b>Nov 9, 1956</b> , that I last saw the deceased alive on <b>12:30 P.M. Nov. 9, 1956</b> , and that death occurred at <b>1:20 P.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>T. J. O'Connell</b>		M.D. <b>Berlin, Maryland</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>11/12/56</b>	
NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>		LOCATION (City, town, or county) (State) <b>BERLIN MD</b>	
DATE REC'D BY LOCAL REGISTRAR <b>11-12-56</b>		REGISTRAR'S SIGNATURE <b>Helen S. Hayward</b>	
24. FUNERAL DIRECTOR <b>Anna A. Burden</b>		ADDRESS <b>Berlin Md</b>	

MARGIN RESERVED FOR BINDING

VS. A15—53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01/11/2011

No No  
Mrs Gandy Davidson, Germantown  
Blanche Phillips  
Hosier & Co  
W. Wadsworth, Jr.  
Patterson / Bennett Bros

9561 87 AU.

RECEIVED

[illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11942 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11918

Reg. Dist. No.

355

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Worcester</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> c. LENGTH OF STAY IN 1b <u>1 year</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St Louis Ave</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> d. STREET ADDRESS <u>St Louis Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>HORACE</u> First <u>Samuel</u> Middle <u>Hastings</u> Last <b>4. DATE OF DEATH</b> Month <u>Nov</u> Day <u>26</u> Year <u>19 56</u>				<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>JAN 3 1882</u> <b>9. AGE</b> (In years last birthday) <u>74</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>FARMING</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Berlin Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Samuel Hastings</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>ANNIE ENNIS</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>  </u> <b>17. INFORMANT</b> <u>ENNIS HASTINGS</u> Address <u>Ocean City, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion acute</u> <u>420.1</u> DUE TO (b) <u>CORONARY Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>002X</u> DUE TO (c) <u>Arterio Sclerotic CVD</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tuberculosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>3 years</u> <u>5 years</u>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>F. J. Townsend Jr.</u> <b>EXAMINER'S NAME (Type)</b> <u>F. J. TOWNSEND JR</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>NOV 26, 56.</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>22b. DATE THEREOF</b> <u>11/28/55</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Buckingham</u> <b>22d. LOCATION</b> (City, town, or county) (State) <u>Berlin Md.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Anna A. Burbage</u> <b>ADDRESS</b> <u>Berlin Md.</u> <b>24a. REC'D BY REGISTRAR</b> <u>NOV 28 1956</u> <b>DATE</b> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Helen Hayward</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for 48 hours.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

BUREAU V. 3

NOV 28 1966

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11943 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11919

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill Route #2</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>	
c. LENGTH OF STAY IN 1b <i>1 Day</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>E.</i> Last <i>Jackson</i>		4. DATE OF DEATH Month <i>Nov</i> Day <i>22</i> Year <i>1964</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 26 - 1937</i>
9. AGE in years (last birthday) <i>26</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Snow Hill, md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Faither Russell</i>		14. MOTHER'S MAIDEN NAME <i>Mamie Jackson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-32-7683</i>	
17. INFORMANT <i>Mrs Hazel M. Martin</i>		Address <i>Snow Hill, md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Corporation of clots</i> 919.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Gunshot wound of Thorax</i> DUE TO (c) <i>minutes</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>shot gun discharged accidentally</i>	
20c. TIME OF INJURY Hour <i>19</i> o. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>home</i>	20f. (City or town) <i>Snow Hill</i> (County) <i>Worcester</i> (State) <i>md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Kendrick Mc Cullough</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Kendrick Mc Cullough</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. DATE OF CREMATION <i>Nov 26/64</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Good Spring Cemetery</i>		22d. LOCATION (City, town, or county) <i>Snow Hill</i> (State) <i>md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clayton Davis</i>		ADDRESS <i>Snow Hill, md</i>	
24a. REC'D BY REGISTRAR <i>NOV 26 1964</i>		24b. REGISTRAR'S SIGNATURE <i>Blayne Cooper</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
NOV 26 1956  
BUREAU V. S.

## 11944 CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>	
c. LENGTH OF STAY IN 1b <u>10 yrs.</u>		d. STREET ADDRESS <u>R.F.D.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Evelyn Virginia Johnson</u> First Middle Last		4. DATE OF DEATH <u>Nov.</u> Month <u>18</u> Day <u>1956</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May, 26, 1926</u>
9. AGE (In years last birthday) <u>30</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>factory farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Viola Purnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-22-8419</u>	
17. INFORMANT <u>Ernest Johnson</u> Address <u>Bishop, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Convulsive Seizure (epilepsy)</u> <u>237x</u> DUE TO <u>Brain tumor</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>8 mos.</u> (c) <u>8 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar 10, 1956</u> to <u>Nov 18, 1956</u> , that I last saw the deceased alive on <u>November 18, 1956</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Loony U. Shelby, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Berlin, Md</u>	
PHYSICIAN'S NAME (Type) <u>Loony U. Shelby, Jr.</u>		DATE SIGNED <u>11/19/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 21, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>	22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u> ADDRESS <u>Pocomoke City, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 11-20-56</u>	24b. REGISTRAR'S SIGNATURE <u>William Bergery</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

NOV 26 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11945 CERTIFICATE OF DEATH

11921 355  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution—Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>WORCESTER</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <b>BURLEY ST</b>		
3. NAME OF DECEASED (Type or print) First <b>LILLIE</b> Middle <b>RAYNE</b> Last <b>JONES</b>			4. DATE OF DEATH Month <b>NOV. 22</b> Day <b>1956</b> Year <b>1956</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 30, 1899</b>		9. AGE (In years last birthday) <b>77</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (State or foreign country) <b>POWELLVILLE MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>TIMOTHY RAYNE</b>			14. MOTHER'S MAIDEN NAME <b>MARTHA LEWIS</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT Address <b>MRS IRMA JESTER BERLIN MD.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>6 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>21 Nov 1956</b> , to <b>22 Nov 1956</b> , that I last saw the deceased alive on <b>22 Nov 1956</b> , and that death occurred at <b>2:50 AM</b> , from the causes and on the date stated above					
ACTUAL SIGNATURE <b>Nathaniel R. Thomas</b> M.D.			ADDRESS (Street, city or town, state) <b>Powellville MD</b> DATE SIGNED <b>23 Nov 56</b>		
PRINTED NAME (Type) <b>Nathaniel R. Thomas MD.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>13-</b>	22b. DATE THEREOF <b>11/25/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT. PLEASANT</b>		22d. LOCATION (City, town, or county) (State) <b>POWELLVILLE MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burboye</b> ADDRESS <b>Berlin Ind.</b>			24a. REG'D BY REGISTRAR <b>Nov 28, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Felicia E. Hayward</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU VI 8

NOV 23 1900

RECEIVED

11923

## 11946 CERTIFICATE OF DEATH

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #1</u>				c. LENGTH OF STAY IN 1b <u>78 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Snow Hill, Rural #1</u>			
3. NAME OF DECEASED (Type or print) First <u>Joal</u> Middle <u>Martin</u> Last <u>Martin</u>				4. DATE OF DEATH Month <u>701</u> Day <u>27</u> Year <u>1956</u>			
5 SEX <u>male</u>		6 COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 4 - 1884</u>	
9. AGE (In years last birthday) <u>72</u>		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>23</u> Hours <u>23</u> Min.		11. IF UNDER 24 HRS. Months <u>12</u> Days <u>23</u> Hours <u>23</u> Min.		12. IF UNDER 1 YEAR Months <u>12</u> Days <u>23</u> Hours <u>23</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>			
11. BIRTHPLACE (State or foreign country) <u>Snow Hill md</u>				12. CITIZEN OF WHAT COUNTRY? <u>md</u>			
13. FATHER'S NAME <u>Cemey Martin</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Purnell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-36-0246</u>			
17. INFORMANT <u>Willie Martin</u> Address <u>Snow Hill md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-vascular</u> DUE TO (c) <u>renal disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 day</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 1</u> , 1956, to <u>Nov 27</u> , 1956, that I last saw the deceased alive on <u>Nov 26</u> , 1956, and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Snow Hill Md</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Paul Cohen</u> M.D.							
PHYSICIAN'S NAME (Type) <u>DR. PAUL COHEN</u>							
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Buried</u>				22b. DATE THEREOF <u>12-1-56</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>				22d. LOCATION (City, town, or county) (State) <u>Snow Hill md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. ...</u> ADDRESS <u>Snow Hill, md</u>				24a. REC'D BY REGISTRAR <u>DATE NOV 28</u>			
				24b. REGISTRAR'S SIGNATURE <u>Walter E. ...</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 23 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11947

## CERTIFICATE OF DEATH

11924

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution residence before admission) o STATE <u>MD</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>S.</u> Last <u>Burnell</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Salaried Consultant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-09-6141</u>	
17. INFORMANT <u>Mr. Jeff C. Young</u> Address <u>Snow Hill, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prostatic Hypertrophy obstruction</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>3 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 16, 1956</u> to <u>Nov. 24, 1956</u> that I last saw the deceased alive on <u>Nov. 23, 1956</u> and that death occurred at <u>1:00</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.		ADDRESS (Street, city or town, state) <u>104 Bay St Snow Hill, Md.</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT C. LA MAR, MD</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Nov 27/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>County Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Snow Hill, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. La Mar</u> ADDRESS <u>Snow Hill, MD</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Elroy Cooper</u>

RECEIVED

NOV 28 1978

1. 10/24/78

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11948

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11925-50

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural POCOMOKE CITY</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural POCOMOKE CITY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R D #2 Box 310</b>		d. STREET ADDRESS <b>R D # 2 Box 310</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWARD THOMAS ROBINSON Jr.</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>22</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4, 1956</b>		9. AGE (in years last birthday) yrs <b>2</b> Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S</b>		13. FATHER'S NAME <b>EDWARD THOMAS ROBINSON</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET EWELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>EDW THOMAS ROBINSON &amp; MARGARET ROBINSON</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>491x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Robert C. La Mar</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11-22-56</b>	
EXAMINER'S NAME (Type or print) <b>Robert C. La Mar, MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>Nov. 25, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cottage Grove</b>	22d. LOCATION (City, town, or county) (State) <b>West Over, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Wharton</i>		ADDRESS <i>new church, etc.</i>		24a. REC'D BY REGISTRAR <b>DATE 11/27/56</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hite</i>

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
NOV 28 1956  
BUREAU

11927

Reg. Dist. No.

351

11949

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark Rural #1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark Rural #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Elton W. Surman</u>		4. DATE OF DEATH <u>Nov. 9 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7 - 1901</u>
9. AGE (in years last birthday) <u>55 1/2</u> yrs.		10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>10</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stamer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm. M. Surman</u>		14. MOTHER'S MAIDEN NAME <u>Candelaria West</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-36-1430</u>	
17. INFORMANT <u>Mrs. Mary J. Surman, Newark, md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia + Anamtion</u> DUE TO (b) <u>Generalized Carcinomatosis</u> DUE TO (c) <u>(primary site undetermined)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 1</u> , 19 <u>56</u> , to <u>Nov. 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 8</u> , 19 <u>56</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.		ADDRESS (Street, city or town, state) <u>104 Bay St. Snow Hill, Md</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT C. LA MAR, M.D.</u>		DATE SIGNED <u>11/10/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Nov. 11/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Unity Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Newark, md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>May O. Shinnis</u> ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR <u>Nov 13 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Thurs. Cooper</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
NOV 11 1956  
BUREAU V. S.

## 11950 CERTIFICATE OF DEATH

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stockton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stockton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>Rural</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Littleton Osborne Trader</b>		4. DATE OF DEATH Month Day Year <b>Nov. 1 19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 8, 1883</b>
9. AGE (In years last birthday) yrs. <b>73</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Hallwood, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Osborne Trader</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Marshall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>221-42-8731</b>	
17. INFORMANT <b>Herman Trader, Stockton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer, Bowel</b> <b>153X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Several Months.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 1, 1956</b> , to <b>Nov. 1, 1956</b> , that I last saw the deceased alive on <b>Nov. 1, 1956</b> , and that death occurred at <b>900am</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Nov. 3, 1956</b>			
ACTUAL SIGNATURE <i>Charles W. Trader, M.D.</i>		PHYSICIAN'S NAME (Type) <b>Charles W. Trader, M.D., Pocomoke City, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 3, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wessells Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Mears Va</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry M. Johnson</b>		ADDRESS <b>Parksley, Va.</b>	
24a. REC'D BY REGISTRAR DATE <b>Nov 7 1956</b>		24b. REGISTRAR'S SIGNATURE <i>Blwyn Cooper</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 11951 CERTIFICATE OF DEATH

Reg. Dist. No. 855

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>LOUISA CATHERINE WARREN</u>				4. DATE OF DEATH <u>Nov. 4 1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 5, 1859</u>	9. AGE (In years last birthday) <u>97</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>GEORGE BRITTINGHAM</u>				14. MOTHER'S MAIDEN NAME <u>KITTY DAVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT <u>MR. CLAUDE WARREN</u>				Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Sub. Nephritis</u> DUE TO (c) <u>Senility</u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>6-1-56</u> to <u>11-4-56</u> , that I last saw the deceased alive on <u>11-1-56</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clifford E. Schott</u> M.D.				DATE SIGNED <u>BERLIN MD</u>			
PHYSICIAN'S NAME (Type) <u>Clifford E. Schott</u>				ADDRESS <u>BERLIN MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/7/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burby</u>				ADDRESS <u>Berlin MD</u>		24a. REC'D BY REGISTRAR <u>DATE 11-7-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>			

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CERTIFICATE OF DEATH

Examine the body  
Examine the body  
Examine the body

Examine the body  
Examine the body

BUREAU V. S.

1956

RECEIVED

Examine the body  
Examine the body